

In the ORS 656.327 Treatment Dispute of
LACRECIA N. BOUTARD, Claimant

Contested Case No: H05-086

PROPOSED AND FINAL ORDER

September 16, 2005

FIDELITY AND GUARANTY INSURANCE CO C/O SEDGWICK CLAIMS
MANAGEMENT, Petitioner
LACRECIA N. BOUTARD, Respondent
Before Lawrence S. Smith, Administrative Law Judge, Administrative Hearings

HISTORY OF THE CASE

Fidelity and Guaranty Insurance Co. c/o Sedgwick Claims Management (Petitioner) timely appealed an October 7, 2004 Administrative Order issued by the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD), Department of Consumer and Business Services. The Order concluded that Petitioner was precluded from challenging a proposed surgery because it failed to comply with OAR 436-010-0250(3). On December 10, 2004, the matter was referred to the Office of Administrative Hearings (OAH) for hearing.

On August 1, 2005, Administrative Law Judge (ALJ) Lawrence S. Smith conducted a telephone hearing. Attorney Eric Miller represented Petitioner and called one witness, Joe Lee. Attorney Christopher Slater represented Lacrecia N. Boutard (Claimant) and called Claimant as a witness. Assistant Attorney General Lori Lindley represented WCD. The record closed that day.

ISSUES

1. Whether Petitioner may present the testimony of its claim examiner and Exhibit 12A.
2. Whether Petitioner submitted a Form 440-3228 (Elective Surgery Notification) within seven days of receiving notice of a proposed medical procedure, as required by OAR 436-010-0250(3).

EVIDENTIARY RULING

The record consists of Exhibits 1 through 50, 12A, 43A, and 49A, which were admitted into the record without objection.

FINDINGS OF FACT

1. Claimant sustained a compensable injury on February 8, 2003. (Ex. 1.) Petitioner accepted L4-5 disc herniation protrusion. (Ex. 5.)
2. On January 31, 2005, Claimant again visited her treating doctor, Dr. Treible, with complaints of pain. He noted pain at the L4-5 level and recommended a repeat discectomy with possible L4-5 fusion. Claimant elected to proceed with surgery. Dr. Treible noted in his chart,

“I am requesting insurance authorization for the above procedure.” (Ex. 12 at 4.)

3. On February 9, 2005, Petitioner sent a letter to Dr. Treible, acknowledging that he had “now formally recommended an L4-5 fusion.” (Ex. 21.) On February 15, 2005, Petitioner referred Claimant to another independent medical examiner (IME), scheduled for March 7, 2005, which cost Petitioner \$600. (Ex. 22.) On February 23, 2005, Petitioner referred Claimant to yet another IME for March 9, 2005, to determine the appropriateness of the fusion. (Ex. 23.)

4. On March 8, 2005, Dr. Treible sent a surgery authorization request form to Petitioner. (Ex. 25.) The next day, Petitioner sent Form 440-3228 to Dr. Treible. (Ex. 26.)

CONCLUSIONS OF LAW

1. Whether Petitioner may present the testimony of its claim examiner and Exhibit 12A.
2. Petitioner did not submit a Form 440-3228 (Elective Surgery Notification) within seven days of receiving notice of a proposed medical procedure, as required by OAR 436-010-0250(3).

OPINION

1. Additional evidence

Claimant objected to the testimony of Petitioner’s witness and Exhibit 12A as new medical evidence or issues, which may not be admitted, pursuant to ORS 656.327(2), which states in relevant part:

Medical review of treatment of worker; findings; review; costs.

* * * * *

(2) * * * At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted.

The objection is overruled. The evidence provides support to Petitioner’s claim that it reasonably expected Dr. Treible to submit a formal request for surgery rather than rely on the earlier letter. Because the evidence relates to Petitioner’s claim that was addressed in the Administrative Order, the evidence is not new or a new issue.

2. Timely response

ORS 656.327 provides for medical review of services provided. WCD has jurisdiction over medical disputes arising under ORS 656.327 where compensability is not at issue. OAR 436-010-0008.¹ MRU’s decision is reviewed for substantial evidence and errors of law.

¹ OAR 436-010-0008 states in relevant part:

Administrative Review and Contested Cases
 (1) Administrative review before the director:

Petitioner has the burden of showing that the Administrative Order is not supported by substantial evidence or that it reflects an error of law. OAR 436-001-0225(1).²

“Substantial evidence exists to support a finding of fact when the record viewed as a whole, would permit a reasonable person to make that finding.” ORS 183.482(8)(c). A finding is supported by substantial evidence if it is reasonable in light of countervailing as well as supporting evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292 (1990). To determine whether substantial evidence exists, a reviewer must:

[L]ook at the whole record with respect to the issue being decided, rather than one piece of evidence in isolation. If an agency’s finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence. ***For instance, and in the context which is likely to occur in workers’ compensation cases, if there are doctors on both sides of a medical issue, whichever way the [director] finds the facts will probably have substantial evidentiary support. [The administrative law judge] would not need to choose sides. The difference between the ‘any evidence’ rule and the substantial evidence test *** will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of the finding and the [director] finds the other without giving a persuasive explanation. *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988).

Petitioner claims there is no substantial evidence for the conclusion in MRU’s Administrative Order that Petitioner was notified of Dr. Treible’s recommendation to perform a L4-5 fusion. Petitioner is entitled to receive actual notice of proposed elective surgery at least seven days prior to the surgery. OAR 436-010-0250(2).³ Petitioner claims it did not receive

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.247, 656.260, and 656.327.

* * *

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

² OAR 436-001-0225(1) states:

Scope of Review/Limitations on the Record

(1) Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested-case hearing.

³ OAR 436-010-0250(2) states:

notice of the proposed surgery until March 8, 2005, when Dr. Treible sent a formal request, but Petitioner actually had notice regarding Dr. Treible's recommendation at least a month earlier, as it conceded in its letter mailed February 9, 2005. (Ex. 21.) This is at least substantial evidence that Petitioner received actual notice from Dr. Treible at that time. Upon receiving such notice, Petitioner has seven days to submit a Form 440-3228 (Elective Surgery Notification) to Dr. Treible. OAR 436-010-0250(3).⁴ Petitioner did not submit a Form 440-3228 until March 9, 2005. Its failure to do so within seven days bars it from "later disputing whether the surgery was excessive, inappropriate, or ineffectual." OAR 436-010-0250(5).⁵

The record contains substantial evidence that Petitioner did not meet the seven-day time limit and is barred from disputing whether the surgery was appropriate.

ATTORNEY FEES

In medical services cases, where a claimant finally prevails in a contested case order by the director, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. ORS 656.385(1). A statement of services may be considered as a factor in assessing the award if submitted within seven days of the hearing date. OAR 436-001-0265(1). Claimant prevailed. Her attorney submitted his Statement of Services within seven days, requesting \$3,700. Absent extraordinary circumstances, the fee may not exceed \$2,000. Claimant's attorney claimed extraordinary circumstances, based on: his experience of eight years; his usual hourly charge of \$200 per hour for non-contingency cases; the 10.7 hours devoted to the appeal and hearing; the value of the claim to Claimant of almost \$50,000, including the cost of surgery, time loss, PPD, and vocational assistance; and the risk that his efforts will go uncompensated. Claimant's attorney did advise Respondent that he would be seeking a substantial fee if required to go to hearing. The hearing lasted 1.7 hours. Petitioner

Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, or the surgeon shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and the approximate surgical date and place if known.

⁴ OAR 436-010-0250(3) states:

When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician. When requested, the consultation shall be completed within 28 days after notice to the attending physician.

⁵ OAR 436-010-0250(5) states:

If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery was excessive, inappropriate, or ineffectual.

filed no response to the Statement. Claimant's attorney has established extraordinary circumstances and is entitled to an assessed fee of \$3,700.

ORDER

The Administrative Order dated October 7, 2004, is affirmed. Claimant is entitled to an attorney fee of \$3,700.